



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a **summary**.** For more information about your coverage, or to get a copy of the complete terms of coverage, <http://www.aetnastudenthealth.com> or by calling 1-877-261-8403. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-877-261-8403 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	Core Network: \$150 per Policy Year / Preferred Care: \$400 per Policy Year / Non-Preferred Care: \$600 per Policy Year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u>?	Yes. Preferred <u>preventive care</u> , Child Wellness Services from birth to age 5, Prescribed Medicine Expense, Preferred Care Pediatric Preventive Dental, Pediatric Vision Services, Prescribed Medicines and certain primary care services, are covered before you meet the <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	For Designated and Preferred Care Combined: Individual: \$7,000/ Family: \$14,000 per Policy Year. Non-Preferred Care Individual: Unlimited/ Family: Unlimited.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	Penalties, <u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.aetna.com/docfind or call 1-877-261-8403 for a list of <u>network providers</u> .	You pay the least if you use a <u>provider</u> in the Core network. You pay more if you use a <u>provider</u> in the Preferred Care network. You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Core Network Provider (You will pay the least)	Preferred Provider (You will pay less)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% <u>coinsurance</u> , after \$25 <u>copay</u> /visit	20% <u>coinsurance</u> , after \$35 <u>copay</u> /visit	40% <u>coinsurance</u> , after \$40 <u>copay</u> /visit	None
	<u>Specialist</u> visit	10% <u>coinsurance</u> , after \$25 <u>copay</u> /visit	20% <u>coinsurance</u> , after \$35 <u>copay</u> /visit	40% <u>coinsurance</u> , after \$40 <u>copay</u> /visit	None
	<u>Preventive care/screening/immunization</u>	No charge	No charge	30% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	LAB: 10% <u>coinsurance</u> XRAY: 10% <u>coinsurance</u> , after \$25 <u>copay</u> /visit	LAB: 20% <u>coinsurance</u> XRAY: 20% <u>coinsurance</u> , after \$35 <u>copay</u> /visit	LAB: 40% <u>coinsurance</u> XRAY: 40% <u>coinsurance</u> , after \$40 <u>copay</u> /visit	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.aetna.com/individuals-families/find-a-medication.html	Generic drugs	\$15 <u>copay</u> /supply (retail), Deductible does not apply.	\$15 <u>copay</u> /supply (retail), Deductible does not apply.	\$15 <u>copay</u> /supply (retail), Deductible does not apply.	Covers up to a 90 day supply (retail) and mail order.
	Preferred brand drugs	\$30 <u>copay</u> /supply (retail), Deductible does not apply	\$30 <u>copay</u> /supply (retail), Deductible does not apply.	\$30 <u>copay</u> /supply (retail), Deductible does not apply.	
	Non-preferred brand drugs	\$45 <u>copay</u> /supply (retail), Deductible does not apply.	\$45 <u>copay</u> /supply (retail), Deductible does not apply.	\$45 <u>copay</u> /supply (retail), Deductible does not apply.	
	<u>Specialty drugs</u>	\$150 <u>copay</u> /supply (retail), Deductible does not apply.	\$150 <u>copay</u> /supply (retail), Deductible does not apply.	\$150 <u>copay</u> /supply (retail), Deductible does not apply.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-certification required, \$500 penalty applies for Non-Preferred Care which is not pre-certified.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Core Network Provider (You will pay the least)	Preferred Provider (You will pay less)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	10% <u>coinsurance</u> , after \$100 <u>copay/surgery</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u> , after \$150 <u>copay/visit</u>	10% <u>coinsurance</u> , after \$150 <u>copay/visit</u>	10% <u>coinsurance</u> , after \$150 <u>copay/visit</u>	<u>Copay</u> waived if admitted. Preferred and Non-Preferred <u>emergency room care</u> cost-share same as Select Care (Emory Core). No coverage for non-emergency care.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-certification required for emergency transportation by airplane, \$500 penalty applies for Non-Preferred Care which is not pre-certified.
	<u>Urgent care</u>	10% <u>coinsurance</u> after \$25 copay/visit	20% <u>coinsurance</u> after \$25 copay/visit	40% <u>coinsurance</u> after \$25 copay/visit	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-certification required, \$500 penalty applies for Non-Preferred Care which is not pre-certified; benefit includes inpatient Rehabilitation Services
	Physician/surgeon fees	10% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <u>coinsurance</u> , after \$10 <u>copay/visit</u> ; All other outpatient services 10% coinsurance	20% <u>coinsurance</u> , after \$10 <u>copay/visit</u> ; All other outpatient services 20% coinsurance	20% <u>coinsurance</u> , after \$10 <u>copay/visit</u> ; All other outpatient services 40% coinsurance	
	Inpatient services	10% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-certification required; \$500 penalty applies for Non-Preferred Care which is not pre-certified.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Core Network Provider (You will pay the least)	Core Network Provider (You will pay the least)	Core Network Provider (You will pay the least)	
If you are pregnant	Office visits	Prenatal: No Charge Postnatal: 10% <u>coinsurance</u> , after \$25 <u>copay</u> /visit Diagnostic LAB: 10% <u>coinsurance</u> Diagnostic XRAY: 10% <u>coinsurance</u> , after \$25 <u>copay</u> /visit	Prenatal: No Charge Postnatal: 20% <u>coinsurance</u> , after \$35 <u>copay</u> /visit Diagnostic LAB: 20% <u>coinsurance</u> Diagnostic XRAY: 20% <u>coinsurance</u> , after \$35 <u>copay</u> /visit	Prenatal: 30% <u>coinsurance</u> Postnatal: 40% <u>coinsurance</u> , after \$40 <u>copay</u> /visit Diagnostic LAB: 40% <u>coinsurance</u> Diagnostic XRAY: 40% <u>coinsurance</u> , after \$40 <u>copay</u> /visit	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Benefit limited to a maximum of 120 Visits per Policy Year. Pre-certification required for home health care (i.e., private duty nursing); \$500 penalty applies for Non-Preferred Care which is not pre-certified.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u> , after \$35 <u>copay</u> /visit	20% <u>coinsurance</u> , after \$35 <u>copay</u> /visit	40% <u>coinsurance</u> , after \$40 <u>copay</u> /visit	Refers to Physical, Occupational & Speech Therapies.
	<u>Habilitation services</u>	10% <u>coinsurance</u> , after \$35 <u>copay</u> /visit	20% <u>coinsurance</u> , after \$35 <u>copay</u> /visit	40% <u>coinsurance</u> , after \$40 <u>copay</u> /visit	
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-certification required, \$500 penalty applies for Non-Preferred Care which is not pre-certified.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.

	<u>Hospice services</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-certification required, \$500 penalty applies for Non-Preferred Care which is not pre-certified.
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	30% <u>coinsurance</u> , <u>Deductible does not apply</u>	Covered through the end of the month in which the covered person turns 19. Benefits are limited to 1 visit per policy year.
	Children's glasses	No Charge	No Charge	30% <u>coinsurance</u> , <u>Deductible does not apply</u>	Covered through the end of the month in which the covered person turns 19.
	Children's dental check-up	No Charge	No Charge	0% <u>coinsurance</u> , <u>Deductible does not apply</u>	Covered through the end of the month in which the covered person turns 19.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u>.)		
<ul style="list-style-type: none"> • Acupuncture (except when used in lieu of anesthesia) • Cosmetic Surgery • Dental Care (Adult) - except accidental injury. 	<ul style="list-style-type: none"> • Long Term Care • Routine eye care (Adult) 	<ul style="list-style-type: none"> • Routine Foot Care • Weight Loss Programs - except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> • Bariatric Surgery • Chiropractic Care 	<ul style="list-style-type: none"> • Hearing Aids • Infertility Treatment 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S • Private Duty Nursing, limited to home health services only

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Georgia Office of Insurance and Safety Fire Commissioner, Customer Services Division, (800) 656-2298, <http://www.oci.ga.gov/consumerservice/home.aspx>.

For more information on your rights to continue coverage, contact the [plan](#) at 1-877-261-8403.

Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html>.

State consumer assistance program, if other than state insurance department: Georgia Office of Insurance and Safety Fire Commissioner, Customer Services Division, 2 Martin Luther King, Jr. Drive, West Tower, Suite 716, Atlanta, GA 30334, (800) 656-2298, <http://www.oci.ga.gov/consumerservice/home.aspx>.

Office of Personnel Management Multi State Plan Program: <https://www.opm.gov/healthcare-insurance/multi-state-plan-program/externalreview/>.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-877-261-8403.
- Georgia Office of Insurance and Safety Fire Commissioner, Customer Services Division, (800) 656-2298, <http://www.oci.ga.gov/consumerservice/home.aspx>.
- Additionally, a consumer assistance program can help you file your [appeal](#). Contact Georgia Office of Insurance and Safety Fire Commissioner, Customer Services Division, 2 Martin Luther King, Jr. Drive, West Tower, Suite 716, Atlanta, GA 30334, (800) 656-2298, <http://www.oci.ga.gov/consumerservice/home.aspx>.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-261-8403.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-261-8403.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-877-261-8403.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-261-8403.

—————[To see examples of how this \[plan\]\(#\) might cover costs for a sample medical situation, see the next section.](#)—————

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$150
■ Specialist copayment/coinsurance	\$25/10%
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$150
Copayments	\$100
Coinsurance	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,510

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$150
■ Specialist copayment/coinsurance	\$25/10%
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$150
Copayments	\$400
Coinsurance	\$700
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,270

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$150
■ Specialist copayment/coinsurance	\$25/10%
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$150
Copayments	\$100
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$450

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD). TTY: 711

To access language services at no cost to you, call 1-877-261-8403.

Para acceder a los servicios de idiomas sin costo, llame al 1-877-261-8403. (Spanish)

如欲使用免費語言服務，請致電1-877-261-8403。(Chinese)

Afin d'accéder aux services langagiers sans frais, composez le 1-877-261-8403. (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-877-261-8403. (Tagalog)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-877-261-8403. an. (German)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-877-261-8403. (Arabic)

Pou jwenn sèvis lang gratis, rele 1-877-261-8403. (French Creole-Haitian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-877-261-8403. (Italian)

言語サービスを無料でご利用いただくには、1-877-261-8403. までお電話ください。 (Japanese)

무료 언어 서비스를 이용하려면 1-877-261-8403. 번으로 전화해 주십시오. (Korean)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-877-261-8403 تماس بگیرید. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-877-261-8403. (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para 1-877-261-8403. (Portuguese)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-877-261-8403 (Russian)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-877-261-8403. Vietnamese)